BQC 93-020 – Supersedes BQC 92-019

Date: April 30, 1993

To: Nursing Homes NH 14
Facilities for the Developmentally Disabled FDD 8

From: Susan Wood, Deputy Director
Bureau of Quality Compliance

Subject: Guardianship Needs for Residents Who May Be Incompetent

A. INTRODUCTION

The purpose of this memo is to revise the Bureau's policy statement about guardianship for nursing home residents, in the context of post-admission substitute decisionmaking. We are replacing BQC Memo 92-019 with this memo in order to change the Sections (E & F) that addressed this aspect of the policy because we have been persuaded that a consensus about the meaning of existing law does not exist on some subjects addressed in the earlier memo.

All other sections of the earlier memo (B, C, D) are reissued with no change. There is a proposal for legislative change under consideration dealing with admissions to nursing homes. If state law is modified, we will then update appropriate sections of this memo.

B. POTENTIAL REGULATORY VERSUS NON-REGULATORY LIABILITY

A facility's potential liability in resident care is not limited to regulatory concerns enforced by the Bureau in its survey and certification procedures. A facility also faces the separate potential liability of a lawsuit filed by the resident's relatives. Other potential types of liability exist as well.

This memo addresses only a facility's potential regulatory liability enforced by the Bureau. The memo only covers what the Bureau believes is a facility's regulatory responsibility to ensure certain rights for incapacitated residents. This is a complex legal area with potential ramification beyond the regulatory arena.

Facilities may wish to obtain their own attorney's opinion on the complex question of whether the policies contained in this memo are sufficient to protect the facility from any potential non-regulatory liability. In other words, it should not be assumed that a facility meeting the requirements of this memo will be protected from liabilities beyond the Bureau's regulatory authority.

C. ADMISSIONS: Voluntary Admission by Competent Adults, Admission Pursuant to a POAHC, and as Otherwise Authorized in Ch. 51 or 55, Wis. Stats.

Wisconsin statutes govern admissions to nursing homes (Ch. 55, Stats.) and ICF/MRs (Ch. 51 or 55, Stats.). These statutes provide the exclusive methods of admission, and such exclusivity has been recognized in an attorney general opinion (OAG 35-88). As a result, there is no recognized informal admission method; such as admission of a parent to a nursing home by family members, or a long-term admission of a ward by a court-appointed guardian (except as allowed in conjunction with protective placement procedures).

All admissions to nursing homes and ICF/MRs are controlled by Ch. 51 or 55, Stats. A certified facility's compliance with these statutes is a federal regulatory concern, pursuant to 42 CFR 483.75(b) (for nursing homes) and 42 CFR 483.410(b) (for ICF/MRs).

The general rule established in Chs. 51 and 55, Stats., is that admission to a nursing home or ICF/MR must meet the requirements of s. 51.20, Stats. (involuntary commitment for treatment); s. 51.15, Stats. (emergency detention); s. 55.06(9), Stats. (regular protective placement proceedings); or s. 55.06(11), Stats. (emergency protective placement). These statutes recognize certain exceptions to the general rule. The four major exceptions are briefly described in the following paragraphs.

The first exception allows a competent adult to voluntarily admit him/herself to a nursing home, pursuant to s. 55.05(5)(a), Stats. A competent adult also may voluntarily admit to an ICF/MR but only with the county's approval, pursuant to s. 51.10,

Stats. However, a competent adult is unlikely to meet the certification, licensing or medical assistance funding criteria for care and services in an ICF/MR (e.g., all admissions to an ICF/MR must be in need of active treatment).

The second exception involves the voluntary admission of a minor child to an ICF/MR, under s. 51.13, Stats., where consent requirements differ for minors below age 14, and minors aged 14 or older (but less than age 18). Note that the county also must approve the admission if the county is to be responsible for the cost of the minor's therapy and treatment. A similar age distinction for the developmentally disabled exists in s. 55.06(1), Stats., which uses age to define eligibility for protective placement in a nursing home or ICF/MR.

The third exception is authorized in s. 55.05(5)(d), Stats., and involves the admission of an incapacitated adult who executed a power of attorney for health care when he/she was competent. The incapacitated adult may be admitted to a nursing home (or ICF/MR) by the health care agent if (pursuant to s. 155.20(2)(c)2., Stats.) one of the following conditions is satisfied: 1) The power of attorney for health care document authorizes admission and the incapacitated individual does not have a diagnosis of mental illness or developmental disability at the time of admission. 2) The admission is directly from a hospital inpatient unit for recuperative care not to exceed three months (and the hospital admission was not for psychiatric care). 3) The incapacitated individual resides with the health care agent and the admission is for 30 or fewer days to allow the health care agent a vacation or release for a family emergency.

The fourth exception pertains to certain short-term admissions by a court-appointed guardian. A court-appointed guardian does not have authority to admit the ward to a nursing home or an ICF/MR on a long-term basis without first complying with proceedings under Ch. 51 or 55, Stats. However, the guardian has some admission authority for short-term stays if one of the following conditions is satisfied: 1) The admission is directly from a hospital inpatient unit for recuperative care not to exceed three months (and the hospital admission was not for psychiatric care), pursuant to s. 55.05(5)(b)2., Stats. 2) The incapacitated individual resides with the guardian and the admission is for 30 or fewer days to allow the guardian a vacation or release for a family emergency, pursuant to s. 55.06(12), Stats. Note the special procedures that apply (s. 55.05(5)(c), Stats.) where the short-term admission under s. 55.05(5)(b), Stats., is protested by the individual being admitted.

D. COMPETENT RESIDENTS HAVE THE RIGHT TO MAKE DECISIONS FOR THEMSELVES

Nursing homes and ICF/MRs are required to obtain each resident's participation in decision-making on certain matters affecting the resident, which mainly pertain to aspects of institutional living and medical treatment. (See, for example, 42 CFR 483.10, 42 CFR 483.420; s. 49.498, Stats.; s. 50.09, Stats.; s. HSS 132.31, Wis. Admin. Code and s. HSS 134.31, Wis. Admin Code.) As a general rule, each resident has the right to decide matters which he/she is competent to decide; meaning matters which the resident is capable of making. Exceptions to this general rule are discussed in part F of this memo.

A resident may have the ability to think through and decide some issues for him/herself, but not all issues. An ICF/MR resident, for example, may be incapable of deciding complex medical treatment options; but the same resident may be capable of deciding what clothes to wear and how to spend his/her own money. On matters which the resident is incapacitated to decide, federal and state law require decisions to be made by substitute decision making methods recognized under state law.

Facilities are required to assess and update each resident's areas of competency. (42 CFR 483.20(b)(2)(vii), 42 CFR 483.20(b)(5), 42 CFR 483.440(c)(3)(v) and 42 CFR 483.440(f)). A psychological evaluation should be done when questions arise regarding the resident's ability to decide specific issues.

E. POST-ADMISSION SUBSTITUTE DECISION MAKING:

This section of the memo addresses methods of substitute decision making for incapacitated residents which will be recognized as meeting the regulatory requirements which the Bureau enforces.

Several methods of substitute decision making for incapacitated individuals are recognized by Wisconsin Statutes and were detailed in prior memos BQC-91-074, dated December 10, 1991 and BQC 92-029 dated June 5, 1992. Also, the Wisconsin Supreme Court issued a decision in 1992 which provides guidance on issues of substitute decision making. (In the Matter of the Guardianship of L.W. v. L.E. Phillips Career Development Center, Eau Claire county, and St. Francis Hospital, 167 Wis., 2d 53 (1992).

1. Court appointment under Ch. 880, Stats., of a guardian for an incompetent ward.

Unless the guardianship was established solely for handling the individual's estate, a court appointed guardian generally has the duty to make medical treatment (and other) decisions on behalf of the ward and in the ward's best interests. This includes temporary guardians who are authorized to make health care decisions. Temporary guardianships are created for 60 days with on 60 day extension possible. After the temporary guardianship expires, the guardian has no authority to make decisions for the ward.

It is important to recognize that certain guardianships may be limited with the ward retaining certain decisionmaking rights. In some cases these may be in the medical area. Also, guardians are not empowered to make certain medical decisions either by case law or statute. Examples are sterilization, live organ donation, electroshock therapy, and psychotherapy.

As a general rule, the Bureau will not cite a facility for following the decisions made by a guardian.

2. Power of attorney for health care (POAHC) document executed under Ch. 155, Stats.

An individual who executes a POAHC (principal) designates another person (agent) as a substitute decision maker for health-care decisions when (and if) the individual becomes incapacitated. The principal may include specific instructions in the POAHC for the agent to follow, may authorize general decision-making powers to the agent, or use a combination of specific and general directives. The agent has the statutory duty to make health-care decisions in accord with the principal's wishes expressed to the agent (or written in the POAHC) when the principal was competent.

Where the principal's wishes cannot be determined, the agent must make health-care decisions based on the principal's best interests. **As a general rule, the Bureau will not cite a facility for following the decisions made by an agent designated under a POAHC.**

3. A living will executed under Ch. 154, Stats.

Unlike in a guardianship or POAHC, there is no other one person named to make decisions on behalf of the signer (the person who executed the living will). Rather, the signer's written instructions "speak" directly to health-care providers. The living will, by statute, is limited to the topic of withholding or withdrawing certain life-sustaining procedures. **As a general rule, the Bureau will not cite a facility for following the contained in a living will.**

Exceptions exist to the general rules recited in the prior paragraphs, such as when there are validity questions regarding a living will or POAHC document, or good reasons exist to question the decision made by a guardian or POAHC agent. The Bureau will expect facilities to seek court guidance when these exceptions exist.

The court which appointed the guardian may be petitioned for guidance where a decision made by a guardian is questioned. The probate court may be petitioned where a decision made by a POAHC agent is questioned, pursuant to s. 155.60(4)(a), Stats. It also may be appropriate to petition a circuit court for guidance in some situations. Facilities may wish to obtain advice from their own attorney on the appropriate court to petition in various circumstances.

Validity questions occur when a facility has good reason to question whether a living will or POAHC document was forged, revoked or otherwise invalid. For example, a family member may provide the facility with a revocation statement and allege that the statement was written by the resident when competent, but other family members say the document was forged.

Another situation is one in which the facility has good reason to question whether the decision made by a substitute decision-maker (a guardian or a health-care agent) is contrary to what the resident would have chosen (if competent); or if the resident's wishes cannot be determined, is contrary to the resident's best interests.

The Bureau will expect facilities, at a minimum, to consider the following information in determining whether good reason exists to question the decision made by the substitute decision-maker: 1) information contained in the files which the facility maintains for the resident (medical record, for example); 2) information from facility staff; and 3) information from the resident's family. The Bureau will expect facilities to seek out and document other relevant information as needed and with regard to the magnitude of the issue addressed.

The following example illustrates circumstances which could give a facility good reason to question the statutory decision-maker's decision. The example is based on a situation which occurred in a facility, but some facts have been changed for purposes of illustration.

The facility resident was not capable of speech and had a court-appointed guardian. The guardian decided that certain life-sustaining medical treatment would be withheld. The resident, however, was conscious and indicated her desire for treatment by nods and gestures which were not random and appeared to have meaning. A facility in this situation should petition the court which appointed the guardian to determine whether the resident is capable of making the decision for herself and, if not, whether the guardian is acting in the resident's best interests.

Statutory methods of decision making do not cover every situation for which a decision must be made on behalf of an incapacitated resident. For example, the resident may not have a POAHC or living will, or perhaps the resident did execute one of those statutory documents but the decision to be made is not covered in the document. It also happens that some incapacitated residents do not have court-appointed guardians. The facility is advised to consult with its own attorney and/or its Ethics Committee about how to respond when there is confusion about the resident's treatment wishes.

If you would like assistance in setting up an Ethics Committee, please contact the Center for the Study of Bioethics at the Medical College of Wisconsin, which offers technical assistance to facilities. The address is 8701 Watertown Plank Road, Milwaukee, WI 53226; telephone is (414) 257-8498. Although the regulations do not mandate ethics committees in nursing homes, the bureau encourages facilities to develop them and use them for formulating facility policy and for resolving case specific issues of substitute decisionmaking.

The Bureau, for regulatory purposes, will accept statutory substitute decision-making methods; and where statutory methods do not apply, will evaluate the facts on a case specific basis when conducting complaint investigations to make a determination about compliance. Facilities should consult with their own attorneys to determine what types of non-statutory methods (if any) their own attorney would recommend as sufficient to protect the facility from other types of potential liability aside from the regulatory authority of the Bureau.